

EXHIBIT E

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 09/03

Geico
P.O. Box 5507
Fredericksburg, VA 22403-9526

ATTN: James Zappa

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)		TRICARE CHAMPUS (Sponsor's SSN)		CHAMPVA (Member ID)		GROUP HEALTH PLAN (SSN or ID)		FEDERAL EMPLOYER (SSN)		OTHER (AU)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0182204370101064	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]										3. PATIENT'S BIRTH DATE [REDACTED]		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME	
5. PATIENT'S ADDRESS (No., Street) [REDACTED]										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) [REDACTED]		8. INSURED'S POLICY GROUP OR FEDERATION NUMBER	
CITY [REDACTED]					STATE [REDACTED]					9. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>					
ZIP CODE [REDACTED]					TELEPHONE (Include Area Code) [REDACTED]					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
11. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]					12. OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED]					13. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					
14. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]					15. OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED]					16. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					
17. EMPLOYER'S NAME OR SCHOOL NAME [REDACTED]					18. INSURANCE PLAN NAME OR PROGRAM NAME Geico					19. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete Item 5 a, d.					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED: [REDACTED] SIGNATURE ON FILE DATE: 08/02/2010										18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below) SIGNED: [REDACTED] SIGNATURE ON FILE					
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident or Pregnancy (LMP)) MM DD YY 12/25/2009										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE [REDACTED]										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Rebate Items 1, 2, 3 or 4 to Item 21e by Lines) 1. 1722.11 3. 1719.42 4. 1719.41										22. MEDICATED RESUBMISSION CODE ORIGINAL REF. NO.					
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER MM DD YY MM DD YY SERVICE EMG OPTIC/PCS MODIFIER POINTER										25. PRIOR AUTHORIZATION NUMBER					
1 08/04/10 08/04/10 11 20551 1234 81010 10 NPI															
2 08/04/10 08/04/10 11 99214 1234 5752 1 NPI															
3										NPI					
4										NPI					
5										NPI					
6										NPI					
26. FEDERAL TAX I.D. NUMBER SSN EIN										27. PATIENT'S ACCOUNT NO					
28. SERVICE FACILITY LOCATION INFORMATION Vasco Flo 2470 Walden Avenue Cheektowaga, NY 14225 NPI										29. TOTAL CHARGE \$ 861.60					
30. AMOUNT PAID \$										31. BILLING PROVIDER INFO & PH # 716 6812968					
32. SIGNATURE OF PROVIDER OR SUPPLIER (I certify that the statements on the reverse copy of this bill are made a part thereof.) Mikhail Sotnikov, MD SIGNED 09/28/2010										33. BILLING PROVIDER INFO & PH # 716 6812968					

NUCC Instruction Manual available at: www.nucc.org

WCMS-1600CS

JMB 0933-0999 FORM CMS-1500 (09/03)

1500

GEICO
750 Woodbury Road
Woodbury, ny 11797-

ATTN: Bruna GLAVAN

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 09/96

PDA

PDA

1. MEDICARE (Medicare #)		MEDICAID (Medicaid #)		TRICARE CHAMPUS (Sponsor's SSN)		CHAMPVA (Member ID#)		GROUP HEALTH PLAN (SSN or ID#)		FECA BLK LUNG (SSN)		OTHER (#)		16. INSURED'S I.D. NUMBER (For Program in Item 1)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE				SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		17. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No. Street)												6. PATIENT'S RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No. Street)					
STATE												8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>				CITY					
ZIP CODE												TELEPHONE (Include Area Code)				STATE					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10d. RESERVED FOR LOCAL USE				11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER												2. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				a. INSURED'S DATE OF BIRTH MM DD YY					
b. OTHER INSURED'S DATE OF BIRTH MM DD YY												b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				b. EMPLOYER'S NAME OR SCHOOL NAME					
c. EMPLOYER'S NAME OR SCHOOL NAME												c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to local complete item 9 and					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.				18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					
SIGNED: SIGNATURE ON FILE												DATE: 09/22/2010				SIGNED: SIGNATURE ON FILE					
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident or Pregnancy) (MM DD YY) 09/22/2010												15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM DD YY) 12a. 12b. 12c. 12d. 12e. 12f. 12g. 12h. 12i. 12j. 12k. 12l. 12m. 12n. 12o. 12p. 12q. 12r. 12s. 12t. 12u. 12v. 12w. 12x. 12y. 12z.				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				19. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
19. RESERVED FOR LOCAL USE												20. MEDICAID RESUBMISSION CODE				21. PRIOR AUTHORIZATION NUMBER					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1, 2, 3 or 4 to item 21E by line) 1. 847-1 2. 847-2 3. 847-3 4. 847-4												22. MEDICAID RESUBMISSION CODE				23. PRIOR AUTHORIZATION NUMBER					
24. A. DATES OF SERVICE From MM DD YY To MM DD YY 09/23/10 09/23/10												B. PLACE OF SERVICE EMG				C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) E. DIAGNOSIS F. CHARGES G. DAYS OF WORK H. EXT. FEE I. ID QUAL J. RENDERING PROVIDER ID. #					
1												2				3					
2												3				4					
3												4				5					
4												5				6					
5												6				7					
6												7				8					
25. FEDERAL TAX ID. NUMBER												26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
28. TOTAL CHARGE												29. AMOUNT PAID				30. BALANCE DUE					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Michael Stratoswsky, MD SIGNED: 10/30/2010												32. SERVICE FACILITY LOCATION INFORMATION Vasca Flo 2470 Walden Avenue Cheektowaga, NY 14225				33. BILLING PROVIDER INFO & PH # 716 6812968					

NUCC Instruction Manual available at: www.nucc.org

WCMS-1500CS

ATTACHED CMS 0988-0999 FORM CMS-1500 (03/05)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

GEICO
750 Woodbury Road
Woodbury, ny 11797-

ATTN: Keisha Daymon

PICA		PICA	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0343445060101114	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME	
3. PATIENT'S BIRTH DATE SEX MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
5. PATIENT'S ADDRESS (No., Street)		CITY STATE	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		ZIP CODE TELEPHONE (Include Area Code)	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		a. INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. EMPLOYER'S NAME OR SCHOOL NAME	
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		c. INSURANCE PLAN NAME OR PROGRAM NAME GEICO	
c. EMPLOYER'S NAME OR SCHOOL NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
d. INSURANCE PLAN NAME OR PROGRAM NAME		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		SIGNED SIGNATURE ON FILE DATE 09-26-2010	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 09-26-2010		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by line) 1. 847-2 3. 847-1		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
2. 1729-2 4. 1723-4		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-9-CM ICD-10 QUAL J. RENDERING PROVIDER ID. #		23. PRIOR AUTHORIZATION NUMBER	
1 09-25-10 09-25-10 11 99214 1234 57.52 1 NPI			
2			
3			
4			
5			
6			
25. FEDERAL TAX ID. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 57.52	
29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Mikhail Strutsousky, MD SIGNED 10/04/2010		33. BILLING PROVIDER INFO & PH # (716) 6812968 Vascu Flo 2470 Walden Avenue Suite 2200 Cheektowaga, NY 14225	

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

GEICO
750 Woodbury Road
Woodbury, ny 11797-

ATTN: Keisha Daymon

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0343445960101114	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]		3. PATIENT'S BIRTH DATE MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) [REDACTED]		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
7. INSURED'S ADDRESS (No., Street) [REDACTED]		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10d. RESERVED FOR LOCAL USE	
11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME GEICO d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 9 a-d.		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED: [REDACTED] SIGNATURE ON FILE: [REDACTED] DATE: 09-26-2010	
14. DATE OF CURRENT: MM DD YY 09-26-2010 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. [REDACTED] 17b. NPI [REDACTED]		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> \$ CHARGES 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
19. RESERVED FOR LOCAL USE 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 847-2 3. 847-1 2. 720-2 4. 723-4		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER 1. 09-24-10 09-24-10 11 20551 1234 56707 7 NPI 2. 09-24-10 09-24-10 11 76942 1234 21132 1 NPI 3. 4. 5. 6.	
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 779.20 29. AMOUNT PAID \$ 4 30. BALANCE DUE \$	
31. PROVIDER OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Mikhail Stratsouskiy, MD SIGNED 10/04/2010		32. SERVICE FACILITY LOCATION INFORMATION Vasco Flo 2470 Walden Avenue Checktowaga, NY 14225	
33. BILLING PROVIDER INFO & PH. # 716 6812968		34. BILLING PROVIDER INFO & PH. # Vasco Flo 2470 Walden Avenue Suite 2200 Checktowaga, NY 14225	

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

GEICO
750 Woodbury Road
Woodbury, ny 11797-

ATTN: Kahili Vieira

PICA		FICA	
1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input checked="" type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0206399750101031	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME	
5. PATIENT'S ADDRESS (No., Street) [REDACTED]		7. INSURED'S ADDRESS (No., Street) [REDACTED]	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Cammarata Yolanda		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME geico		12. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete Item 9 a-d.	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE DATE 08/31/2010		14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 02/14/2009	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. [REDACTED] 17b. NPI [REDACTED]		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. L847-0 2. L722-2 3. [REDACTED] 4. [REDACTED]		22. MEDICAID RESUBMISSION CODE 23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #			
1 09/28/10 09/28/10 11 76942 12 21132 1 NPI			
2 09/28/10 09/28/10 11 20551 12 8101 1 NPI			
3		NPI	
4		NPI	
5		NPI	
6		NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 202.33	
29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Mikhail Strutsouk, MD SIGNED 10/04/2010		32. SERVICE FACILITY LOCATION INFORMATION Vascu Flo 2470 Walden Avenue Cheektowaga, NY 14225 a. NPI [REDACTED] b. [REDACTED]	
33. BILLING PROVIDER INFO & PH. # (716) 6812968			

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

GEICO
750 Woodbury Road
Woodbury, ny 11797-

ATTN: Kahili Vieira

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)		1a. INSURED'S I.D. NUMBER (For Program In Item 1) [REDACTED]	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]		3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
4. PATIENT'S ADDRESS (No., Street) [REDACTED]		5. PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
6. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) [REDACTED]	
8. PATIENT'S EMPLOYMENT Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		9. INSURED'S CITY STATE ZIP CODE TELEPHONE (Include Area Code) [REDACTED]	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10d. RESERVED FOR LOCAL USE		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 9 a-d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED: [REDACTED] SIGNATURE ON FILE DATE: 08-31-2010		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: [REDACTED] SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 02 14 2009		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
18. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> \$ CHARGES		19. MEDICAID RESUBMISSION CODE ORIGINAL REF NO	
20. PRIOR AUTHORIZATION NUMBER		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by line) 1. 847-0 3. _____	
22. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		23. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11 20551	
24. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		25. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11 76880	
26. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		27. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11 99213	
28. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		29. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
29. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		30. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
31. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		32. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
33. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		34. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
35. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		36. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
37. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		38. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
39. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		40. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
41. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		42. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
43. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		44. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
45. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		46. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
47. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		48. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
49. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		50. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
51. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		52. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
53. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		54. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
55. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		56. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
57. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		58. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
59. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		60. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
61. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		62. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
63. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		64. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
65. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		66. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
67. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		68. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
69. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		70. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
71. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		72. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
73. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		74. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
75. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		76. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
77. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		78. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
79. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		80. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
81. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		82. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
83. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		84. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
85. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		86. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
87. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		88. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
89. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		90. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
91. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		92. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
93. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		94. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
95. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		96. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
97. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		98. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	
99. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09-23-10 09-23-10		100. PLACE OF SERVICE EMG CPT/HCPCS MODIFIER 11	